



BONE DENSITY PATIENT HISTORY QUESTIONNAIRE

NAME: _____ TODAY'S DATE: _____
SEX: FEMALE MALE CURRENT HEIGHT (INCHES): _____
DATE OF BIRTH: _____ WEIGHT (LBS): _____
REFERRING PHYSICIAN: _____ AGE OF MENOPAUSE: _____
ETHNICITY: _____

1. HAVE YOU HAD A PREVIOUS HIP OR VERTEBRAL FRACTURE? YES NO
2. HAVE YOU HAD ANY FRACTURES DURING YOUR ADULT LIFE, WHICH DID NOT RESULT FROM SIGNIFICANT TRAUMA? YES NO
3. DID EITHER OF YOUR PARENTS EVER HAVE A HIP FRACTURE? YES NO
4. DO YOU CURRENTLY SMOKE? YES NO
5. HAVE YOU EVER TAKEN PREDNISOLONE OR ANY OTHER STEROIDS? YES NO
6. HAVE YOU EVER BEEN DIAGNOSED WITH RHEUMATOID ARTHRITIS? YES NO
7. DO YOU HAVE SECONDARY OSTEOPOROSIS? (EXAMPLE: LIVER DISEASE, DIABETES, EARLY MENOPAUSE) YES NO
8. DO YOU DRINK THREE OR MORE ALCOHOLIC DRINKS PER DAY? YES NO
9. ARE YOU CURRENTLY BEING TREATED FOR OSTEOPOROSIS? YES NO

10. HAVE YOU EVER TAKEN ANY OF THE FOLLOWING MEDICATIONS?

- | | |
|---|---|
| <input type="radio"/> ACTONEL (i.e. RISEDRONATE) | <input type="radio"/> BONIVA (i.e. IBANDRONATE) |
| <input type="radio"/> EVISTA (i.e. RALOXIFENE) | <input type="radio"/> FORTEO (i.e. PARATHYROID HORMONE) |
| <input type="radio"/> FOSAMAX (i.e. ALENDRONATE) | <input type="radio"/> HRT (i.e. ESTROGEN/HORMONE THERAPY) |
| <input type="radio"/> MIACALCIN (i.e. CALCITONIN) | <input type="radio"/> PROTELOS (i.e. STRONTIUM RANELATE) |
| <input type="radio"/> RECLAST (i.e. ZOLEDRONATE) | <input type="radio"/> PROLIA (i.e. DENOSUMAB) |
| <input type="radio"/> VITAMIN D | <input type="radio"/> CALCIUM |

11. LIST ALL MEDICATIONS CURRENTLY TAKING: _____

12. DO YOU HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS?

- | | |
|---|---|
| <input type="radio"/> ANOREXIA OR BULIMIA | <input type="radio"/> ANY SEIZURE DISORDERS |
| <input type="radio"/> ASTHMA OR EMPHYSEMA | <input type="radio"/> CANCER |
| <input type="radio"/> END STAGE RENAL DISEASE | <input type="radio"/> INFLAMMATORY BOWEL DISEASES |
| <input type="radio"/> HYPERPARATHYROIDISM | <input type="radio"/> HYSTERECTOMY |

LIST ANY MEDICAL CONDITIONS THAT ARE NOT LISTED: _____

13. WHAT WAS YOUR MAXIMUM HEIGHT IN INCHES? _____
14. DO YOU PERFORM WEIGHT BEARING EXERCISE REGULARLY? YES NO
 15. DO YOU REGULARLY CONSUME DAIRY PRODUCTS? YES NO
 16. DO YOU DRINK CAFFEINATED BEVERAGES? YES NO

IF YOU ARE A WOMAN:

17. AT WHAT AGE DID YOUR MENSTRUATION BEGIN? _____
18. ARE YOU PREMENOPAUSAL? YES NO
19. HOW MANY FULL TERM PREGNANCIES HAVE YOU HAD? _____
20. WHEN YOU HAD YOUR MENSTRUATION NORMALLY, DID YOU EVER MISS IT FOR MORE THAN 6 MONTHS IN A ROW? (NOT INCLUDING PREGNANCIES OR MENOPAUSE) YES NO

21. TO THE BEST OF MY KNOWLEDGE, I AM NOT CURRENTLY PREGNANT. SIGNATURE: _____